

Gloria Johnson

Chief Medical Officer – CM Health

Dear Gloria

Thank you for asking me to visit The Women's Health Service at Counties Manukau. I visited on 3 days and spoke to SMO's from Obstetrics and Gynaecology, Anaesthesia, General Surgery, management and nursing staff. This is the final report incorporating the feedback received.

Counties Manukau Women's Health Service is unique in New Zealand. It is the busiest service, has the most pathology, looks after women with significant obesity issues and has a variety of demographics.

The SMOs who work in the service are dedicated, hardworking and competent. However, there was significant emotional distress amongst those interviewed. A series of adverse outcomes, the loss of a colleague, resignation of two senior colleagues and the relentless nature of 'on call' has resulted in a very disillusioned workforce.

At present the total FTE is 21.61, the on-call roster is 1 in 16, and there are 12.5 gynaecological operating lists per week.

I note since the review that Women's Health has appointed four new specialists starting December, February and two in March 2019, and further advertising was in progress.

Update 6/3/19: Further successful interviews. Now progressing the appointment process for three further SMOs (with some years of experience); one as an initial FTC.

OBSTETRICS ISSUES

Although the birth rate has dropped from a high of 8,225 to 7,816, the absolute number of obesity 2 and 3 patients has gone up from 726 to 885. Over 50% of patients booked have a BMI of 35 or greater. The other interesting fact is the timing of emergency LUSCS. Last year 611 were performed between 8am and 5pm; 337 between 5pm and 10pm; and 593 between 10pm and 8am.

In that later group 265 were classified obese 1, 2 or 3. This is a large number of high risk women that have their LUSCS when the rest of the hospital is at its lowest staffing levels.

Another issue is the lack of a team structure with regards to inpatient obstetric care. The care is provided by the on-call team changing daily, which runs the risk of a lack of continuity of care and potentially a lack of decision making.

With the on-call arrangements, there appears to be a reluctance to call the back-up person because they will be working the next shift.

I gather prior to Christmas a separate dedicated weekend on-call SMO system was put in place to avoid this. For weekdays, clinical duties are cancelled the following day if the second on-call has been required to work during the night.

At present there are also a number of junior registrars, which is compounding the feeling of "relentlessness" of work when the SMO is on-call.

The Diabetic Clinic is a major issue. They are overwhelmed by the demand. They do not have the resource to follow the guidelines, which is adding to the stress of those working in the clinic. They are

continually worried that they will miss something. Apart from lack of staff they also have concerns about lack of space to see the patients.

GYNAECOLOGY

The Acute Gynaecology service is also run by the on-call team. Again the risk of this is lack of continuity with no one person or team taking responsibility for the care of the individual patient. This can result in a delay in treatment.

There are also concerns about accessing acute theatres although there is work happening around that.

One of the major issues from the gynaecologists is the lack of control over their operating lists. The service is also concerned about the unmet need for patients with pelvic pain and uro-gynaecology as they do not often meet the criteria to be seen in clinic. This particularly affects those specialists with an interest in these clinical areas.

The demand on elective services also means that patients are admitted acutely and operated on acutely, which puts added pressure on the acute services.

There is also a concern about the lack of outsourcing and the fact that what outsourcing there is goes to a non-staff member.

Update: Additional resource has since been provided for outsourcing. This has commenced with working through a back-log of outpatient hysteroscopy cases (200). A procurement process has now commenced for use of a private facility with anaesthetic and nursing staff for use by DHB employed Gynaecologists and trainees.

GENERAL ISSUES

There have been issues with rostering and leave. The roster is only coming out the Friday before the next week, and difficulty in getting leave, plus multiple last minute changes. There have been a series of rostered changes with the current employee not coping. Additional support has been provided by NRA, and the job is being scoped to determine whether additional FTE is required. The master roster is not up-to-date, with leave or swaps.

Update: This has reached a point of crisis with now clinical safety issues rather than just frustrations (incorrect after hour's roster and delay in finding corrected individual). This has been elevated through NRA, and to the CMO, and further assistance is being sort. This has been added to the DHB risk register.

There is a feeling of no time to think, rushing from one gap to another.

The lack of resource for the Clinical Director has resulted in her spending considerable time on sorting out rosters, fire-fighting, etc. with having limited time to strategise and increase her visibility to the Service.

The concerns with accreditation for training positions with RANZCOG was raised on several occasions. The last report from RANZCOG also raised that possibility with the next reaccreditation visit due in January 2020.

RECOMMENDATIONS:

- Implementing the recommendations of the 2012 Report.
- A team structure to look after obstetrics and gynaecology in patients with the aim of improving continuity of care. This will require a dedicated project manager.
- More support for rostering and leave provision. This has the potential to move from frustration to having an effect on clinical safety.
- An Anaesthetic Consultant on-site after hours.
- Expand on the audits of the outcomes for those pregnant women with BMIs of over 50. At the same time look at trying to reduce the number of emergency LUSCS done between 10pm and 8am.
- The Diabetic Clinic needs more resource, both in staff and physical space.
- All day elective LUSCS lists should be implemented.
- Outsourcing of gynaecological electives if possible should be to those gynaecologists who are employed by Counties Manukau. Exploring the possibilities of hiring facilities from private hospitals and using Counties Manukau staff, including registrars, to ensure their operating numbers are adequate.
- Gynaecologists should have more control over the operating list, taking into account clinical priority and waiting time. An effort should be made to address the unmet need for patients with pelvic pain and uro-gynaecological symptoms.
- A job-sizing exercise for SMOs, ensuring that they get adequate non-clinical time.
- Adequate resource to support the Clinical Director, to enable the Clinical Director to have time to strategise and increase her visibility to the Service.

Counties Manukau is in a unique position that in it could be a centre for excellence for the management of obesity related problems in women's health. Closer liaison with the University of Auckland may help attain that goal.

The SMO's who I spoke to are dedicated and hard-working who are committed to their service. They need more administrative support to realise their potential.

My final comment is that I found it quite distressing to see the emotional distress of my colleagues, and I hope change can happen to alleviate this distress.

Kindest regards

John Tait

MB, BS FRANZCOG FRCOG

05/03/2019

Refer over

APPENDIX A

A list of potential quick wins:

1. Ventouse equipment in delivery suite. [REDACTED] would be the contact. Cell saver availability
2. All-day elective LUSCS lists
3. Rosters and leave allocation in a timely manner
4. More input from SMO's into their gynae lists
5. Clinical Nurse Specialist (CNS) in EPAC Clinic, to provide some continuity of care
6. Three SMO's to continue on the weekends
7. More resource for the Diabetic Antenatal Clinic
8. Social Worker resource for perinatal losses
9. Clinical input into the outsourcing of gynaecological patients
10. Support for a Pre-term Birth Clinic

I think the important ones are 1,2,3,4 and 9.